Leawood Family Care

Medical History

Name _____ DOB _____

Reason for visit: _____

_____

_____

Allergies:	Reaction:

Current and Prior Medical Conditions: (Please circle option that applies or write in if not listed)

Arthritis	High blood pressure	Thyroid disease	
Anemia	Osteoporosis	Diabetes (type 1 or type 2?)	
Cancer	Stomach/digestive disease	Kidney disease	
Heart disease	Lung disease	Other:	
High cholesterol	Menopause		

Medication (Prescriptions & OTC Vitamins/Supplements) [Attach list or use back of page if needed]

Name & Dose	How often?	What for?

Social History: (Circle options listed and/or write answer on line provided)

Do you drink alcohol? YES or NO
If No: Did you in the past? YES or NO
When did you quit? _____
If Yes: How often? [4 or more times a week, 2-3 times a week, 2-4 times a month, Monthly or less]
How many drinks per occasion? [1-2 drinks, 3-4 drinks, 5-6 drinks, 7-9 drinks, 10 or more]
How often did you have 6 or more drinks on one occasion in the past year? [Never, Less than monthly, Monthly, Weekly, Daily]

Do you use tobacco? YES or NO
If No: Did you in the past? YES or NO If Yes: When did you start? _____ When did you quit? _____
If Yes: What kind? Cigarettes, Cigars, E-sig, Chewing tobacco, other: _____
On average, how much do you currently smoke daily? _____
When did you start smoking? _____
When did you quit smoking? _____
Have you used illegal or "street" drugs recreationally in the past 12 months? YES or NO
If Yes: What kind? _____

Do you drink caffeine beverages (tea, coffee, or cola)? YES or NO If Yes: How much daily? _____
Do you exercise? YES or NO If Yes: What kind? _____ How often per week? _____

Marital status: Single Married Separated Divorced Widowed
Do you have children? YES or NO If Yes: How many? Sons: _____ Daughters: _____

Do you feel safe at home? YES or NO
Are you worried that in the next month, you may not have stable housing? YES or NO
In the last 12 months, have you missed any medical appointments because you didn't have transportation? YES or NO
Within the last 12 months, have you been worried that your food would run out before you were able to buy more? YES or NO

Present Occupation: _____

Family History: Circle condition(s) that apply to your relative.

Father:	Alive / Deceased [age_____] Healthy High blood pressure High cholesterol Heart disease Cancer [type? _____] Diabetes [type? _____] Depression Other serious conditions:	Mother:	Alive / Deceased [age_____] Healthy High blood pressure High cholesterol Heart disease Cancer [type? _____] Diabetes [type? _____] Depression Other serious conditions:
Brother	Alive / Deceased [age_____] Healthy High blood pressure High cholesterol Heart disease Cancer [type? _____] Diabetes [type? _____] Depression Other serious conditions:	Sister	Alive / Deceased [age_____] Healthy High blood pressure High cholesterol Heart disease Cancer [type? _____] Diabetes [type? _____] Depression Other serious conditions:
Brother	Alive / Deceased [age_____] Healthy High blood pressure High cholesterol Heart disease Cancer [type? _____] Diabetes [type? _____] Depression Other serious conditions:	Sister	Alive / Deceased [age_____] Healthy High blood pressure High cholesterol Heart disease Cancer [type? _____] Diabetes [type? _____] Depression Other serious conditions:
Other		Other	

Surgical History: (Include approximate dates if known)

Hospitalizations: (Include reason for admission or diagnosis if known)

Health Maintenance: (*Please provide dates of tests if known*)

Bone Density _____

Colonoscopy _____

Eye Exam _____

Mammogram _____

Vaccination: (*Please provide dates of immunization if known*)

HPV _____

Pneumonia _____

Shingles _____

Tetanus _____

LEAWOOD FAMILY CARE, P.A.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

(Please Check One)

☐ I,_____, have received a copy of Leawood Family Care, P.A.
Patient

Notice of Privacy Practices.

☐ I,_____, refuse to accept a copy of Leawood Family Care, P.A.
Patient

Notice of Privacy Practices.

_____ _____
Signature of Patient Date

LEAWOOD FAMILY CARE

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, LEAWOOD FAMILY CARE may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to LEAWOOD FAMILY CARE'S Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. LEAWOOD FAMILY CARE reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to LEAWOOD FAMILY CARE Privacy Officer at 11301 Ash, Leawood, KS 66211.

With my consent, LEAWOOD FAMILY CARE may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, LEAWOOD FAMILY CARE may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, LEAWOOD FAMILY CARE may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that LEAWOOD FAMILY CARE restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to LEAWOOD FAMILY CARE'S use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent LEAWOOD FAMILY CARE may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

LEAWOOD FAMILY CARE, P.A.
FINANCIAL POLICY

Leawood Family Care participates with a variety of insurance plans. We also provide services to patients who choose to see us as out of network providers. Please be aware, you will incur more out of pocket expenses if medical services provided are out of your insurance network. It is your responsibility to know the coverage and participation details of your specific health insurance company.

We will submit claims on your behalf to your primary insurance carrier and one secondary insurance carrier (if applicable). However, please remember your health insurance is an agreement between you and your insurer and it is your responsibility to know and understand the coverage, benefits, and requirements of your health insurance plan.

If you do not have an insurance card/insurance information for you or your dependent, we will not be able to send a claim to your health insurance carrier for services rendered that day. However, we would be happy to see you or your dependent without insurance information and will ask for payment in full for that day's services. You may subsequently seek reimbursement from your insurance company or provide us your information later and we will submit a claim for you. Upon our subsequent receipt of payment from your insurance company, we will reimburse you for any redundant payment already paid by you.

Any charges due to Leawood Family Care because of unmet deductibles, co-insurance, non-covered services, and out of network services are your responsibility.

If you do not have health insurance, payment in full is expected at the completion of services. Some payment may be required before services are rendered. We accept cash, check, Visa, Mastercard, Discover, and American Express. There will be an additional $40.00 charge for returned checks.

Requirements for Each Visit

- Bring your insurance card and photo ID.
- Allow us to keep a current photo of you on file.
- Pay your copay and non-covered services at the time of services rendered.
- Provide a current phone number and current physical address.
- Validate our office participation with your insurance company and obtain a referral to see us if required.

We may choose not to render services if the requirements above are not met.

Credit Card/Debit Card Authorization Policy

Our financial policy requires that a credit card or debit card be placed on file prior to being seen by our providers. This card will be charged only if your account has a past due balance. Co-pays are not included as they will be collected at the time services are rendered.

After each visit with us we will file a claim on your behalf to your health insurance company. After your insurance company processes your claim, Leawood Family Care will e-mail/mail a statement to the e-mail address/address on file providing you with any balance due that is your responsibility. If we do not receive payment by the due date on the statement, we will process the balance due to your card on file. If the card on file is invalid then your account may be turned over to a collection agency. If you have questions or concerns about your bill, you must contact us prior to the due date listed on your statement.

The security of your information is of the utmost importance. Your card information is stored by our credit merchant company, who specializes in this process. Our staff does not have access to your card information. No personal medical information is stored with this company. We will not need to swipe your card again as long as it is active.

Motor Vehicle Accidents

Regardless of where a motor vehicle accident occurs, your state of residence determines how claims are processed for services provided related to motor vehicle accidents. Missouri residents will have claims processed as usual through their health insurance company.

Kansas law stipulates that health insurance does not cover medical services related to motor vehicle accidents. Therefore our financial policy requires Kansas residents who are being seen for motor vehicle accident related issues to pay in full at the time services are rendered. You may subsequently seek reimbursement from the appropriate auto insurance company or guilty party involved in the accident.

Worker's Compensation

If you are being seen for a work related medical condition, your claim cannot be filed through your health insurance. Claims must be filed through worker's compensation insurance carried by your employer. We must receive all appropriate claim information from your place of employment prior to rendering services.

Treatment of Unaccompanied Minors

A minor (age less than eighteen years) may be seen and treated without a parent's consent only in very special circumstances. If a parent desires their minor child to be treated without the parent being present, written permission, signed and dated by the parent, must be sent with the unaccompanied minor. The minor is expected to provide required payment, insurance information, required referrals if necessary, picture ID and credit/debit card info if not on file.

Payment Plans

Payment plans for balances due to Leawood Family Care may be available under certain circumstances. These must be arranged with and approved by our billing department manager.

Appointment Cancellations/No Shows

Persons who do not show for a scheduled appointment will be billed a no show fee ranging from $25.00 - $75.00 depending on the type of appointment. If you need to cancel a scheduled appointment please do so as much in advance as possible. Appointments cancelled less than 24hour notice may be subject to a no show charge.

Your signature below indicates that you authorize Leawood Family Care to charge your credit card/debit card if appropriate as described in our credit/debit card authorization policy, and that you have read and agree to this financial policy in its entirety.

_____ Print Patient Name

_____ Patient Date of Birth

_____ Patient or Legal Guardian Signature

_____ Date

Billing Office- 913-319-0106
Billing Manager- 913-319-0117
Office Administrator-913-319-0111

COMMUNICATION OF PROTECTED HEALTH CARE INFORMATION

To include appointments, test results, billing information, etc.

The information on this form will be in effect for 1 year from the date signed. It is the patient/guardian responsibility to inform our office of need to amend this form.

Please initial and date the applicable statements below:	Initial	Date
I give Leawood Family Care permission to leave **non-specific information (nature of call only)** on voicemail or answering machine at my home or cell	_____	_____
I give Leawood Family Care permission to leave **specific medical information (test results/billing information/etc.)** on voicemail or answering machine at my home or cell	_____	_____

I give Leawood Family Care permission to discuss my **medical care/billing concerns** with the following people:

_____ _____

Print name of **ANOTHER INDIVIDUAL** Print name of **ANOTHER INDIVIDUAL**

_____

Print **PATIENT NAME**

_____ _____

PATIENT OR GUARDIAN SIGNATURE Date

Patient mailing address: _____

_____

Home phone: _____ Cell phone: _____

Email address: _____

_____ _____ _____

Emergency Contact Relationship Phone number

Leawood Family Care

Mary Ann Campbell, M.D.

Louis D. Christifano, D.O.

John H. Horton, M.D.

Kerry B. Jordan, M.D.

Lisa A. Winkler, M.D.

Stella Zhang, D.O.

Deborah Brown, APRN

Brianna B. Finch, DNP, APRN

Katlyn C. Hilton, DNP, APRN

Evelyn C. Nwaomah, BSN, MHA
Office Administrator

Leawood Family Care Opioid Prescription Policy

Prescription pain medications may be provided if deemed appropriate treatment for acute or certain medical problems as determined by a physician.

Federal Law requires:

All Schedule II medications must be picked up by the person (in the event a patient is incapacitated, a representative may pick up the prescription after approval from the prescribing physician).

Prescriptions can not longer be mailed to the patient or pharmacy.

Individuals picking up their prescriptions will be required to present a valid photo ID.

Prescription renewals will be provided only by the physician actively managing the medical condition unless that physician is unavailable and has made arrangements with a covering provider in this practice.

Prescription renewals will not be provided on weekends or after hours.

Patients requiring pain medications beyond six (6) months or conditions determined to be chronic and requiring long-term opioid medications to manage symptoms (reduce pain, improve function and/or increase independence in activities of daily living) may be required to sign a pain contract or be referred to a long-term pain clinic.

_____ _____

Signature Date